ARTRS
Arkansas Teacher Retirement System

Form # 221
Revised 07/2015
1400 West Third, Little Rock, AR 72201
Phone (501) 682-1517 or (800) 666-2877
Fax (501) 682-2359
Website - www.artrs.gov

Application to Participate in the Teacher Deferred Retirement Option Plan (T-DROP)

Member Information

Member's Name_____ SSN_____

Mailing Address_____

City _____ State _____ Zip _____

Telephone Number (____) _____ E-mail Address _____

Enrollment in the Optional T-DROP Program with ATRS

You must meet eligibility requirements and **submit** this application form by **May 31st** in order to enroll in the optional T-DROP plan with ATRS on July 1, _____ (*yyyy* effective date).

Your election to participate in T-DROP is **irrevocable** and all your future benefits with ATRS will accrue in the T-DROP plan upon the effective date of your participation. T-DROP benefits are only payable when you retire and begin drawing annuity benefits from ATRS.

By signing this election form, you acknowledge that you are required to continue as an active employee with an ATRS covered employer to participate in T-DROP. You also acknowledge that you will no longer earn additional service credit. Salary earned after entering T-DROP will not be used in your retirement annuity calculation.

Member's Signature _____ Date _____

Note: It is your responsibility to submit the application to ATRS by May 31st.
You will be sent written confirmation once your application has been processed.

Employer Verification of Final Salary and Service for T-DROP

This section must be completed by all your ATRS covered employers (including public colleges and universities) that you received salary from this fiscal year. (Make copies of this form as needed.)
Note: Employee contributions are not withheld after a member begins participating in T-DROP.

Member's Name _____

Member's SSN _____

Name of Employer _____

Enter the projected amount of regular or contract salary and number of days worked for the members last year of employment ending June 30.

Total number of days worked this fiscal year: _____

Total salary for this fiscal year $_____

Provide the last date the member will receive a salary payment from the employer for this fiscal year: ____/____/____
(MM / DD / YYYY)

Representative Name (Please Print) _____ Title: _____

Telephone Number (____) _____ E-mail Address _____

Representative Signature _____ Date: _____